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Testimony before the Senate Committee on Veterans' Affairs; by
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Concerns have been expressed about the long average length of stay at Veterans Administration (VA) hospitals. Although VA has taken steps to reduce the length of stay, it is still longer than for comparable patients in community hospitals. Patients often occupy acute care facilities during diagnosis, while waiting for surgery, and during convalescence. VA's plans for sizing of new hospitals are based on this inappropriate use of acute care facilities. GAO developed a new hospital sizing model which determines levels of care that should have been provided. The model also projects bed needs for the future by determining requirements for five age groups of the veteran population. Adoption of GAO's planning approach could lead to reduction in construction costs, increased efficiency, and improved quality of patient care. GAO disagreed with VA's plan to construct a new hospital in Camden, New Jersey, and felt that the Philadelphia VA Hospital was adequate for expected workloads. VA has not given adequate consideration to priorities in its hospital construction proposals. VA's hospital bed requirements could be significantly affected by policies concerning treatment of veterans with other than service-connected disabilities. (HTW)

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STATEMENT OF
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BEFORE THE
COMMITTEE ON VETERANS' AFFAIRS
UNITED STATES SENATE
ON

REVIEWS OF VA'S
PLANNING FOR HOSPITALS

Mr. Chairman and Members of the Committee, we are pleased to be here today to discuss our reviews of VA's planning for hospitals.

As you know, we have been reviewing this area at the request of the Chairman, Subcommittee on HUD-Independent Agencies, Senate Committee on Appropriations. On May 20, 1977, 1/ we issued a report on three of the eight hospitals VA has been authorized to construct over the next several years. My testimony today is based on that report and the results of our review to date on the other five hospitals. Because we have not completed our review, some of the observations we are presenting must be considered as tentative. We expect to complete our work in March 1978.

1/Letter report to the Chairman, Subcommittee on HUD-Independent Agencies, Senate Committee on Appropriations (HRD-77-104, May 20, 1977).

A matter which has been of concern to the VA, to the National Academy of Sciences and to us over the past several years, is the long average length of stay which patients in VA hospitals generally experience. VA has taken steps to reduce the length of stay in VA hospitals and has made progress, but the length of stay remains much longer than for patients of the same age and diagnosis in community hospitals.

Patients are generally admitted to community hospitals only after being "worked-up"--that is, examined and tested to some extent--by a private physician on an outpatient basis. If hospital care is deemed necessary, the patient is scheduled for admission, admitted at the designated time, given necessary treatment and then released. The patient may then spend some additional time convalescing either at home or in a convalescent or nursing home. The patient may also be seen later for more outpatient care.

The delivery of health care in the VA system is often quite different. Patients are often worked-up while occupying an acute care bed. Those determined not in need of further medical treatment are discharged. Sometimes patients in need of surgery spend several days in the hospital waiting to be scheduled for surgery, that is, waiting for the results of diagnostic tests, availability of an operating room and the appropriate surgeon. After

being treated, and recovering from the acute phase of illness, patients often then spend the convalescent period again occupying an acute care bed.

We believe part of the reason for the current situation is that existing VA hospitals were designed many years ago when the model for health care centered around the acute care hospital. As a result, the VA system is comprised mainly of acute inpatient facilities and constrained by the lack of sufficient lower care options. Over the years, due to the general increase in the average age of the veteran population and the shift of medical practice toward greater substitution of outpatient for inpatient care, these other requirements for care have been accommodated for the most part in the facilities mainly available to VA-- existing acute care VA hospitals.

A study we issued in 1973 ^{1/} found that average length of stay in VA hospitals could be significantly reduced through greater use of outpatient and nursing home care, and better scheduling of surgery. As part of this study a random sample of patient medical records were selected at six VA hospitals and reviewed by the treating physicians. On this basis, we estimated that about 146,000 or 15 percent, of the 1 million hospital days furnished at these six hospitals during fiscal year 1971 could have been avoided.

^{1/}"Better Use of Outpatient Services and Nursing Care Bed Facilities Could Improve Health Care Delivery to Veterans" (B-167656, April 11, 1973).

Our most recent work goes the next step and determines what effect this inappropriate utilization of acute care beds has on VA's planning for new hospitals. We found that VA's approach to sizing replacement hospitals relies on historical patient workload data as the basis for estimating future bed requirements. However, the historical data reflects the workloads of a health care delivery system constrained by a lack of appropriate alternatives to acute care as well as poor patient scheduling practices.

VA's current hospital sizing method makes no explicit attempt to estimate the extent to which patients who occupied acute care beds in the past could more appropriately be served in less costly non-acute care settings. Using VA's approach, the inefficiencies which result from existing facility constraints and limitations are carried forward and lead to overestimates of acute care requirements, and underestimates of extended care and outpatient needs.

VA is now undertaking an \$800 million capital investment program to replace seven of its existing hospitals and to build one new one. We believe that in planning these and all future VA facilities every effort should be made to bring the VA health care delivery system more in line with modern and cost effective medical practice by providing the proper mix of acute and non-acute care facilities.

In order to assess these requirements, we developed a new hospital sizing model which analyses historical patient utilization in VA hospitals. Contrary to VA's planning approach, our model determines what different levels of care should have been provided, rather than simply what was provided. The model accomplishes this by analyzing the actual length of stay experienced by every patient discharged from a VA hospital in fiscal year 1976, and comparing it against the average length of stay of patients of the same age and diagnosis in community hospitals. The analysis is carried out by the computer and can be done very quickly for any VA hospital. The community hospital length of stay is extracted from a very large national data base of non-federal acute care hospitals, which represents about 40 percent of all patients discharged by community hospitals in the U.S.

The computer determines both the actual length of stay experienced by each VA patient, and the corresponding community hospital stay, which is almost always shorter. The computer then assigns the community hospital length of stay as the acute care stay for the patient, and the remainder of the days as the non-acute phase of the illness. When compiled over all the thousands of patients in a VA hospital during a one year period, we believe this approach provides a reasonably accurate profile of what the acute care and non-acute care workloads should have been.

The non-acute care patient days, are also distributed among the appropriate lower level care requirements such as intermediate care, nursing home care, rehabilitation, non-acute psychiatric care, and outpatient care. We apportioned the non-acute beds developed by our model on the basis of the National Academy of Sciences' study of health care for American veterans. The result is a redistribution of the current VA patient load to the most suitable levels of care.

Another important feature of the model is the way it projects bed needs into the future. It does this by first determining the hospital requirements for each of five age groups of the veteran population. For example, the model would determine the beds currently needed to support the needs of veterans under age 24, those 25-44, 45-54, and so on. Then, knowing how each age group is expected to change in size in future years, the model can project proportional changes in hospital bed needs. This is important because in many areas of the nation, the overall veteran population may be decreasing at the same time that the number over 65 is expected to more than double. Since veterans tend to use VA hospitals more often when they are older and have longer lengths of stay when they do use them, the changing age pattern becomes a primary consideration. We believe this age specific procedure represents an improvement over

VA's methods of projection and better reflects the way the changing age profile will affect future VA hospital requirements.

For the seven replacement hospitals, our model estimated acute care bed needs which were lower than VA's proposals in four cases, equal in one case, and higher in two cases. Our estimates for individual hospitals ranged from 36 percent fewer beds than VA proposes to 39 percent more beds than VA proposes (see appendix).

We believe that adoption of our planning approach can lead to several benefits. First, large reductions in construction costs should be possible. Recent data indicated that construction of VA nursing homes costs about \$45,000 per bed while VA acute care hospitals cost about \$170,000 per bed. As we shift construction from the acute care type to the extended care type, considerable cost savings should accrue.

Another benefit should be increased efficiency of operations. Development of staffing standards, for example, is very difficult when the day to day workload on a hospital ward can fluctuate from all acute care to all non-acute care patients.

By providing acute care beds only for the acutely ill patients, workloads in the various patient areas should remain more constant and allow for better planning and

more efficient staffing patterns for both nurses and physicians.

Another benefit, and perhaps the most important, should be improved quality of patient care. The design of a system which provides the appropriate level of care for each type of medical requirement would, in our opinion, represent an improvement in the efficiency, timeliness and overall quality of VA health care delivery.

As you know Mr. Chairman, for fiscal year 1978, the Appropriations Committees cut the VA hospital construction budget \$10 million (100 beds) as a result of their belief that the VA was in danger of becoming oversupplied with acute care beds. As you also know, agreement was reached among your Committee, the Senate Appropriations Subcommittee on HUD-Independent Agencies, VA, and us that VA would assess carefully our sizing model in developing estimates for bed needs for the three facilities included in our May 20, 1977, report; and where the estimates derived from the GAO model did not agree with the VA estimates based on its own techniques, VA would report to the Congress a detailed justification for the differences between its and GAO's conclusions. This same procedure was to be used for future estimates.

It was also agreed that VA and GAO would meet to develop a mutually acceptable model. We have had contacts with VA and are attempting to jointly develop a sizing model which will be acceptable to both of us.

In addition to replacing seven existing VA hospitals, VA also planned to construct a new hospital in Camden, New Jersey. Construction costs were estimated at \$75.3 million and about \$32 million annually in operating costs. This hospital was to be located 7 miles from the existing Philadelphia VA Hospital, and was to consist of 360 hospital beds and a 120-bed nursing home care unit. Both the Philadelphia and the Camden VA Hospitals, as well as other VA hospitals in the area, were to be operated concurrently to serve the area's veterans. Justification of the need for the new hospital was based on the result of VA's demographic analysis which was carried out using data from 1966 to 1974.

We reviewed VA's analysis in light of more recent data and disagree with VA's conclusions. Our own analysis indicated that construction of more acute care medical and surgical beds in this area was unwarranted since the Philadelphia VA Hospital is fully adequate in size to handle the expected future workloads. The occupancy rate of medical and surgical beds in the Philadelphia VA Hospital has been declining for the past several years and is currently about 80 percent. Using VA's guidelines, this means that VA has a surplus of beds in a VA hospital 7 miles from the site of this proposed new Camden hospital. While we believe construction of a new VA hospital in Camden would be unjustified,

construction or acquisition of a VA nursing home in the area may be needed. This decision however should await the findings of VA's nationwide nursing home care study which is nearing completion.

We note that in VA's fiscal year 1979 budget submission to the Congress, the Camden hospital project has been cancelled. Instead VA proposes to build an outpatient clinic in Camden and to construct a 120-bed nursing home care addition at the Philadelphia VA hospital.

Another consideration in planning hospital construction programs is the question of priorities. Which new VA hospitals should be constructed first? VA could not explain from a priority standpoint the basis used to select hospitals for replacement from among all VA hospitals in the Nation. VA currently operates 172 medical, surgical, and psychiatric hospitals which were constructed between 1888 and 1976. About 41 percent of VA hospital beds nationwide are in facilities constructed prior to 1947. About 10 percent were constructed in the 1920's or earlier and some date back to before the turn of the century. While VA indicated that the hospitals proposed for replacement were overcrowded and/or obsolete, it could not provide information to show that they were the facilities in greatest need systemwide. It is notable that three of the seven hospitals to be replaced, Little Rock, Baltimore, and Seattle, were opened in the early 1950's.

We believe the Congress should require that VA justify all new hospital construction proposals, in terms of priority, on the basis of a clear and explicit set of objective criteria before funding is approved. The criteria should be used by VA to evaluate and compare the current level of adequacy of existing VA hospitals in all parts of the Nation in meeting the medical needs of veterans. Highest priority for new VA hospital construction should be established in areas of the Nation where existing VA hospitals are least able to provide high quality medical care to the veteran population.

VA has recently developed a process to determine priorities for new hospital construction or replacement based on comparisons between existing facilities and other criteria. However, this process is not to be applied to the eight hospitals in VA's current construction program. This system is called the Space and Functional Deficiency Identification system. We believe the system is a major improvement over the previous way in which decisions were made to replace hospitals. We believe, however, that several modifications are needed in order to improve the system. We are currently reviewing this system and plan to complete our audit work about March 1978.

The final topic which we wish to discuss today involves policy matters which could have significant impact on VA's hospital bed requirements. These matters revolve around

the question of who should we plan to treat in VA hospitals of the future.

The overriding obligation of the VA has been to care for veterans with service-connected disabilities. However, at the seven hospitals proposed for replacement we found that only between 3 and 14 percent of the patients treated during fiscal year 1976 were treated for service-connected conditions. Over the years, as health care costs have escalated, VA's role has increasingly become one of providing low income veterans with hospital based medical services. About half of all VA patients nationwide are eligible for VA care only because they certify that they cannot afford treatment elsewhere. Since VA follows a policy of treating nonservice-connected illnesses on a space available basis, we believe the Congress needs to address the question of whether new and replacement facilities should be sized to accommodate the entire current workload or whether some limitation should be imposed.

HEW recently estimated that 20 percent of the Nation's 931,000 non-Federal hospital beds are surplus. Excess bed capacity has become a national concern. While the government bears the cost of new VA hospital beds, it also shares through Medicare, Medicaid, and other Federal programs, the rising hospital costs resulting from excess community hospital beds.

The passage of some form of national health insurance could have dramatic impact on VA hospital size requirements. If national health insurance is enacted, some veterans who now use the VA for their health needs will use community facilities instead. We have not independently assessed the expected change in demand for VA health care services under national health insurance. However, in light of the large proportions of nonservice-connected veterans being treated in VA hospitals, the existing large excess capacity of community hospital beds, and the uncertainty regarding VA's appropriate future role in the nation's health care delivery system, we believe the Congress should be very conservative in evaluations of the size requirements for new hospitals.

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This concludes my statement Mr. Chairman. We would be happy to respond to any questions you or other Members of the Committee may have.

COMPARISON OF ACUTE CARE BED NEEDS
IN 1985 FOR VA REPLACEMENT HOSPITALS

<u>Hospital</u>	<u>VA proposal (beds)</u>	<u>GAO estimate (beds)</u>	<u>Percentage difference</u>
Richmond	500	500	-
Bay Pines	540	610	+13
Martinsburg	267	371	+39
Little Rock (Roosevelt Road Div.)	535	475	-11
Portland	698	578	-17
Seattle	368	244	-34
Baltimore	430	372	-13